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B. Categories of Care: As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of 8 hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver or caregivers providing at-home care for the recipient. Respite care is limited to not more than 5 consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered Services.

1. As required under Medicare and applicable to Medicaid, the hospice itself must provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that shall be available but are not considered "core" services are physician services, drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language/pathology services, and any other item or service which is specified under the plan and which is reasonable and necessary for the palliation and management of terminal illness and for which payment may otherwise be made under Title XIX.

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3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill must have been completed by the physician, or physicians as required by 12 VAC 30-130-480, and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

5. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

   a. Nursing Care: Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

   b. Medical Social Services: Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

   c. Physician Services: Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

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d. Counseling Services: Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term Inpatient Care: Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable Medical Equipment and Supplies: Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and Biologicals: Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by Medicare and the Department of Health. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

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i. Rehabilitation Services: Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible Groups. To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director, or the attending physician and the physician member of the interdisciplinary team, must certify the life expectancy.

19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A, in accordance with Section 1915(g)(1) of the Act.

A. Provided, with limitations. See Supplement 2 for detail

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20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

A. The same limitations on all covered services apply to this group as to all other recipient groups.

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20b. Services for any other medical conditions that may complicate pregnancy.

A. The same limitations on all covered services apply to this group as to all other recipient groups.

21. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary of Health and Human Services.

21a. Transportation.

A. Transportation services are provided to Virginia Medicaid recipients to ensure that they have necessary access to and from providers of all medical services. Both emergency and nonemergency services are covered. The Single State Agency may enter into contracts with friends of recipients, nonprofit private agencies, and public carriers to provide transportation to Medicaid recipients.

21b. Services of Christian Science nurses.

A. Not provided.

21c. Care and services provided in Christian Science sanitoria.

A. Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

A. Provided, no limitations.

21e. Emergency hospital services.

A. Provided, no limitations.

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21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

A. Not provided.

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22. Emergency Services for Aliens

A. No payment shall be made for medical assistance furnished to qualified aliens who entered the U.S. on or after August 22, 1996, who are not eligible for Medicaid for 5 years after their entry, and non-qualified aliens, including illegal aliens and legal non immigrants who are otherwise eligible, unless such services are necessary for the treament of an emergency medical condition of the alien.

B. Emergency services are defined as: Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

1. placing the patient's health in serious jeopardy;

2. serious impairment of bodily functions; or

3. serious dysfunction of any bodily organ or part.

For purposes of this definition, emergency treatment of a medical condition does not include care and services related to either an organ transplant procedure or routine pernatal or postpartum care.

C. Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

D. Claims for conditions which do not meet emergency criteria for treament in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.